MEDICARE LEARNING NETWORK -
COMPUTER/WEB-BASED TRAINING

DIAGNOSIS CODING - USING THE ICD-9-CM

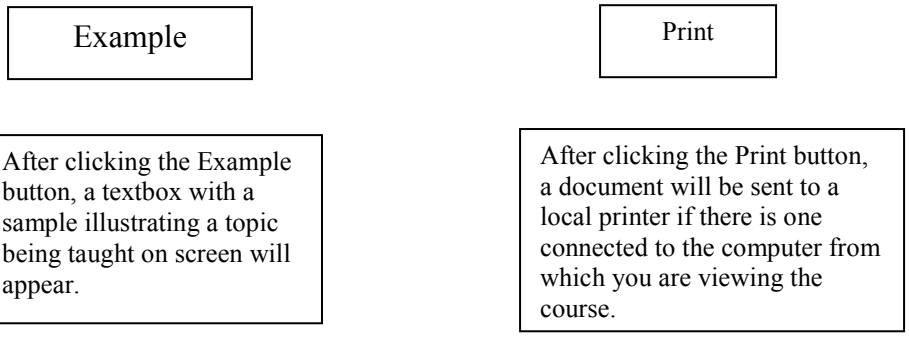
Welcome to … Diagnosis Coding: Using the ICD-9-CM CBT course!

The purpose of this course is to:

- Teach the basics of how to select accurate diagnosis codes from the ICD-9-CM volumes
- Use diagnosis codes correctly on Medicare claim forms

The course lessons begin with an introduction to diagnosis coding and proceeds through five other lessons of instruction on how to use industry guidelines and the ICD-9-CM manual to code efficiently and accurately. CALL 1-800-621-8335 FOR INFORMATION ABOUT HOW TO OBTAIN AN ICD-9-CM MANUAL.

In addition to screen text and images used to present information, you will see an Example button and a Print button.



Use the Help screen to answer any additional questions you may have about other course features. Click the Options button to access Help.

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You will also see two characters appear at different times in the course.

There may also be other images throughout the course that you can click for more information. Be sure to read the prompt line for instructions.

Before we begin the actual course, you will go through a Preliminary Knowledge Assessment. This assessment will help identify what information you already know so that it can be compared to the knowledge you gain by taking this course.

Once the Preliminary Knowledge Assessment is complete, you can access all the lessons from the course's Main Menu. The lessons should take you a little less than an hour to complete, but can be done at your own pace.

After reviewing all of the lessons, you can take the Post-Course Knowledge Assessment and see what you learned.

Note: You will need the most recent version of the ICD-9-CM volumes to answer Preliminary Knowledge Assessment, Practice, and Post-Course Knowledge Assessment questions. Call 1-800-621-8335 for information about how to obtain an ICD-9-CM manual.

You must begin with the Preliminary Knowledge Assessment to determine how much you already know about Diagnosis Coding and the ICD-9-CM volumes.

This brief Assessment asks you to answer a series of questions relating to diagnosis coding. Assessment feedback is given after you have answered all the questions to help you understand your level of knowledge of the course subject matter.

You can enter the course once the entire Preliminary Knowledge Assessment has been completed.

! IMPORTANT !

Make sure you select an answer on each screen before clicking the Right Arrow button to continue. You are not allowed to go back to screens in the Preliminary Knowledge Assessment, and any screens without an answer selected will count as incorrect.

Preliminary Knowledge Assessment

Select each statement below that is true of diagnosis codes.

- Diagnosis codes are numeric or alphanumeric codes translated from medical terminology that are used for each service and/or item provided by a physician's office or other healthcare facility.
- Diagnosis codes are used to determine how much money a provider will get for procedures performed at a healthcare facility.
- Diagnosis codes are used to help evaluate the appropriateness and timeliness of medical care.
- Five-digit diagnosis codes are only necessary when there has been an accident or injury.

Match each ICD-9-CM component with the volume in which you would find that component.

Hypertension Table	Volume 1: Tabular/Numeric List of Diseases
The majority of fifth digit information	
Procedure codes for hospitals	Volume 2: Alphabetic Index of Diseases
Main terms and subterms	Volume 3: Alphabetic Index and Tabular List of Procedures
Three digit categories	

Match each ICD-9-CM convention with the description of its use.

"see"/"see also"/"see category"	Used to enclosed synonyms, alternate working, or explanatory phrases
[ ] brackets	Conditions following this term are to be coded elsewhere
Excludes	Term directs you to other symptoms or conditions
NOS	The equivalent of "unspecified"; this is used to provide codes for nonspecific conditions

Using your ICD-9-CM volumes, translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Acquired night blindness due to Vitamin A deficiency

Using your ICD-9-CM volumes, translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Benign arterial hypertension with renal failure

Select the accurate diagnosis code(s) from the list based on the narrative description given below.

Narrative description: Uncontrolled adult-onset diabetes with gangrene manifestation

- 785.4
- 250.7, 785.4
- 250.72, 785.4
- 250.72

Find the diagnosis code that is accurate for identifying the location and severity of the burn described below.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Third degree burns on all fingers of the right hand, including the thumb

Translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Malignant tumor in the upper, inner quadrant of the left breast, previous malignancy in lower, inner quadrant

Match each step of translating a narrative description into a diagnosis code to the number that represents when you would perform that step.

1	Locate the code from the Alphabetic Index in the Tabular Index (Vol. 1).
2	Ensure you have considered all color coding marks that exist (e.g., age and sex) before selecting the final code.
3	Look up the main term in the Alphabetic Index (Vol. 2) and scan through the subterms if necessary. Follow any references.
4	Observe the punctuations, footnotes, cross-references, color-code prompts, or other conventions present in Vol. 1 for your code. Also determine the appropriateness of the code selection by checking the Includes, Excludes, additional digit requirements, or other instructional

_____ are codes used when treatment or diagnosis is necessary for a condition or problem that is not caused by a disease or injury, but due to certain circumstances. These circumstances often involve contact with healthcare facilities or personnel, and usually affect a person's health status.

- H codes
- C codes
- V codes
- E codes

Why are E codes used? Select all that apply.

- To describe additional details of an accident or event.
- As a classification for external causes of injury and poisonings.
- To describe annual physicians' office visits.
- As a required classification code for all Part A and Part B providers.

Select each statement below that is true regarding diagnosis codes and Medicare claim forms.

- Only paper claims are accepted by Medicare contractors.
- The HCFA-1500 is the main paper claim form used by Medicare Part B providers.
- The External Cause of Injury (form locator 77) is used by Medicare to determine the reimbursement level at which a healthcare facility will receive payment for inpatient services.
- The Diagnosis Code field (24-E) on the HCFA-1500 form can contain up to four codes per line.

What field on the HCFA-1500 form should contain the most significant reason for the visit or encounter?

- Admitting Diagnosis (form locator 76)
- Diagnosis Code (field 24e)
- Other Diagnosis Codes (form locator 68-75)
- Diagnosis or Nature of Illness or Injury (field 21)

When is the Written Advanced Notice form necessary?

- Whenever the item or service is considered "medically necessary," but only covered once annually.
- For all items or services provided.
- Each time an item or service is rendered that may not be considered "medically necessary".

Select all the items that are important to efficient and accurate coding.

- Code to the lowest level of specificity
- Code according to symptoms only, and not suspected diagnoses
- Code to the highest level of specificity
- Code for all notes in the medical record, even "rule out" or suspected conditions
- Use only the most current version of the ICD-9-CM

Good try! You scored ____ correct on the Preliminary Knowledge Assessment.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

It is advised that you proceed through all course lessons, beginning with lesson one, to increase your understanding of diagnosis coding and the ICD-9-CM volumes.

The following course lessons provide an introduction to diagnosis coding and coding guidelines. There is a detailed explanation of the ICD-9-CM contents. Examples and printable job aids are also offered to assist your learning throughout the course.

After completing the lessons, proceed to the Post-Course Knowledge Assessment to answer questions and receive your final score and course certification.

- Introduction to Diagnosis Coding
- The Three Volumes
- Coding Conventions
- Other ICD-9-CM Sections
- Completing the Forms
- Difficult Diagnosis Coding Situations
- Post-Course Knowledge Assessment

Introduction to Diagnosis Coding

After completing this lesson, you should be able to:

- Identify the definition of diagnosis coding.
- Identify the uses of diagnosis coding information.
- Identify HCFA coding guidelines.
- Identify coding tips for inpatient, outpatient, and other specific coding situations.

YOU WILL NEED AN ICD-9-CM MANUAL TO COMPLETE THIS COURSE. CALL 1-800-621-8335 FOR INFORMATION ABOUT HOW TO OBTAIN AN ICD-9-CM MANUAL.

What is Diagnosis Coding?

Proper diagnosis coding involves using the ICD-9-CM volumes to identify the appropriate codes for items or services provided (as recorded in the patient record), and using those codes correctly on medical claim forms.

The diagnosis codes submitted on claim forms (and on other medical documentation) are generally used to determine coverage.

The codes are also used by outside agencies or organizations to forecast healthcare needs, evaluate facilities and services, review costs, and conduct studies of trends in diseases over the years.

Click the hotword and Medicare Expert for more important information.

Medicare Expert: Although getting paid is a very important issue for physicians' offices, *physicians should never code for reimbursement purposes only.*

Coding solely for reimbursement can be misconstrued as fraud. Remember, your office must maintain medical documentation to support the diagnoses reported.

Select the correct definition of diagnosis coding from the list.

- Converting only those services provided by surgeons into medical codes.
- Assigning codes to the medical equipment used to perform services on a patient.
- Translating narrative medical terminology for items and services provided (as written in the patient record) into a code.

History of Diagnosis Coding

1600s	Some form of medical diagnostic coding dates back to seventeeth century England.
1948	The ICD-9 (without the "CM" for Clinical Modification) was used for coding in the U.S. from 1948 to 1977.
1977	The ICD-9-CM, or International Classification of Diseases, Ninth Revision, Clinical Modification, was published for use in 1977.
1988	Since the passage of the Medicare Catastrophic Coverage Act of 1988, providers have been required to submit a diagnosis code on claim forms in order to receive reimbursement.

ICD-9 vs. ICD-9-CM

The original intent of the ICD-9 was to:

- Record morbidity and mortality information for statistical purposes
- Index hospital records by diseases
- Store and retrieve data

The Clinical Modification (CM) allowed the data to be used to:

- Classify morbidity data for reporting
- Compile and compare healthcare data
- Assist in evaluating the appropriateness and timeliness of medical care for review purposes
- Assist in planning healthcare delivery systems
- Establish patterns of patient care among healthcare providers
- Analyze payments for healthcare
- Conduct epidemiological and clinical research

Revisions to the Manual

Diagnosis coding changes for Volumes 1 and 2 are approved annually by a federal committee. The changes take effect each year on October 1. Volume 3 is revised annually by HCFA.

Annual updates to Volume 1 and 2 include changes such as:

- Additional new codes
- Deletion of old ICD-9 codes
- Revisions to descriptors

Publishers of the ICD-9-CM volumes use a variety of symbols or formatting conventions to identify changes in their manual from year to year.

How are diagnosis codes on medical claim forms and other medical documentation used by agencies outside of your office?

- To help evaluate the appropriateness and timeliness of medical care
- To assist in planning healthcare delivery systems
- To establish patterns of patient care among healthcare providers
- To determine the level of reimbursement
- To conduct epidemiological and clinical research

Select the items from the list that are included as revisions in annual updates to the ICD-9-CM volumes.

- Compiled list of five digit codes
- Additional new codes
- Condensed list of valid four-digit codes
- Deletion of old ICD-9 codes
- Revisions to descriptors

The coding and reporting requirements published in 1994 by the Health Care Financing Administration (HCFA) had a large impact on diagnosis coding as well.

They outlined some basic steps that physicians should use to ensure correct coding.

These steps include:

1. Use the ICD-9-CM codes which describe the patient's diagnosis, symptom, complaint, condition, or problem.

2. Use the ICD-9-CM code that is chiefly responsible for the item or service provided.

3. Assign codes to the highest level of specificity. Use the fourth and fifth digits when indicated as necessary in your ICD-9-CM volumes.

4. Do not use suspected diagnoses. Code only the diagnosis symptom, complaint, condition, or problem reported. Medical records, not claim forms, should reflect that the services were provided for "rule out" purposes.

5. Code a chronic condition as often as applicable to the patient's treatment.

6. Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions which no longer exist.)

Select each true HCFA coding guideline from the list.

- You must code to the highest level of specificity.
- Code the diagnosis, symptom, complaint, condition, or problem that is chiefly responsible for the visit.
- The originating physician should code for all conditions for which the patient is being treated.
- Code only reported symptoms or problems, not suspected diagnoses.
- Code a chronic condition only the first time the patient is treated.

Other coding tips include:

- In an emergency situation, the coder should identify the acute conditions or symptomology for outpatient services.
- For inpatient services, list what the conditions are "due to."
- For multiple injuries, always sequence the most severe injury first.
- For causes of infections, code them as secondary.
- Limit use of unlisted diagnosis codes to situations where there is no definitive information available, or there is no other specific code available.
- Distinguish between acute and chronic whenever the ICD-9-CM makes the distinction.
- For inpatient coding on a UB-92, code each medical condition identified in the medical record.
- Revise billing charge tickets and forms periodically to include up-to-date ICD-9-CM codes.

Note: This is only a handful of the significant times you should keep in mind when coding. Contract your local contractor for more information.

Select each true coding tip from the list.

- Acute and chronic conditions are coded the same way.
- Code causes of infection as primary.
- For inpatient services, list what the conditions are "due to."
- For multiple injuries, always sequence the most severe injury first.

The Three Volumes of the ICD-9-CM

After completing this lesson, you should be able to:

- Identify the components of the ICD-9-CM.
- Identify characteristics of the ICD-9-CM components.
- Identify how each volume is used.
- Identify specific terms or codes from the ICD-9-CM volumes given sample descriptions.

The ICD-9-CM is made up of three main volumes.

- Volume 1: Tabular/Numerical List of Diseases
- Volume 2: Alphabetic Index of Diseases
- Volume 3: Tabular and Alphabetic Index of Procedures

Volumes 1 and 2 are used for physician billing and contain diagnostic codes and symptoms.

Volume 3 is used for hospital and skilled nursing facility billing and contain codes for both surgical and non-surgical procedures.

The majority of this course will focus on Volumes 1 and 2. An overview and some details about the contents of Volume 3 are covered in one lesson of this course.

- Volume 1: Tabular/Numerical List
- Volume 2: Alphabetic Index
- Volume 3: Tabular/Alphabetic Index

Review of the ICD-9-CM Volume

Volume 1: Tabular/Numerical List of Diseases

1. Classification of Disease and Injuries
    - Used to find codes for use on medical forms/documents.
    - Contains 17 chapters with disorders grouped by body systems or condition.
    - Each chapter contains:
        - Chapter headings
        - Categories
        - Subcategories
        - Subheadings
        - Sections
        - Fifth-Digit Subcategories

2. Supplementary Classifications (V and E codes)

3. Appendices

Volume 2: Alphabetic Index of Diseases

This volume contains:

1. Alphabetic Index to Diseases
    - Used to look up main term references listed in Volume 1.
    - Contains menu terms and modifiers.
    - Should not be used as a source to code in most cases. (The Hypertension and Neoplasm tables are the exception.)

2. Table of Drugs and Chemicals

3. Alphabetic Index to External Causes of Injury and Poisoning

Volume 3: Tabular and Alphabetic Index of Procedures

This volume is used by hospitals and skilled nursing facilities as an index, and to code.

Match each volume to the correct description of that volume's use.

Volume 1	This volume is used as an index to look up code references to another volume. The volume contains alphabetical listings of terms and modifiers organized alphabetically and by diagnosis, symptom, or condition.
Volume 2	This is the tabular/numerical list of diseases. This volume is used to find the final codes for use on claim forms via chapters, chapter headings, subheadings, categories, sections, subcategories, and fifth-digit subcategories.
Volume 3	This volume is used by hospitals and skilled nursing facilities as an index and final resource for diagnosis codes.

In which volume would you find the Hypertension and Neoplasm Tables?

- Volume 1
- Volume 2
- Volume 3

In which volume would you find seventeen chapters of disorders organized by body system or condition?

- Volume 1
- Volume 2
- Volume 3

ICD-9-CM Coding Conventions

After completing this lesson, you should be able to:

- Identify the significance of the ICD-9-CM coding conventions.
- Identify correct and incorrect codes based on ICD-9-CM conventions and instructions.

There are many abbreviations, punctuation, symbols, typefaces, and formatting conventions used in the ICD-9-CM.

The formatting conventions used in the ICD-9-CM are fairly exclusive to each volume.

Some formatting conventions are also specific to a publisher. For example, many publishers of the latest versions indicate somehow that a code needs a fifth digit in order to be coded correctly, but the symbol used to indicate the need may be different for each publisher.

Volume 2 (the Tabular List) includes the following conventions:

	Examples
"see" --Indicates the coder should look up the term specified to find the correct code.	Limb - see *condition*
"see category" --Indicates the coder should review the category specified before assigning the code.	Abscess Brain Late effect - *see category 326*
"see also" --Indicates additional information is available that may provide the coder with an additional diagnostic code.	Akinetic (see also epilepsy) 345.0
"NEC" (Not elsewhere classified) --A code including NEC should only be used when the coder lacks precise information to code the term to a more specific category; or with terms for which a more specific category is not provided in the tabular list, and no amount of additional information will alter the selection of the code.	NEC: Infection Wound (local) (Post-traumatic) NEC 958.3
Nonessential Modifiers --Nonessential modifiers follow the main terms in a series of parentheses. The presence or absence of these modifiers have no effect on the selection of the code for the main terms.	Nonessential Modifiers: Hematocele (congenital) (diffuse) (idiopathic) 608.83

Essential Modifiers

--Subterms that are listed below the main term in alphabetical order (with the exception of "with" and "without") and indented. Each one clarifies the previous term and in indented further to the right. If there is only one term, it is separated from the main term by a comma.

Essential Modifiers:

Gingivitis 523.1
  Acute 523.0
    Necrotizing 101

Eponyms

--Terms listed as both main terms in their appropriate alphabetic sequence, and under the main terms "Disease" or "Syndrome." A description of the disease or syndrome is usually listed in parentheses following the eponym.

Eponyms can be looked up in several ways.

Example: Gullain-Barré Syndrome

1. Polyneuritis, polyneuritic infective (acute);
2. Syndrome, Gullain-Barré (Strohl);
3. Disease, diseased Gullain-Barré;
4. Gullain-Barré disease or syndrome

(Any of the terms above will show a listing for the Gullain-Barré Syndrome.)

Notes:

-- The notes formatting in Volume 2 further define terms or clarify information. Conventions for formatting the notes area may differ from publisher to publisher, but typically they are boxed off and clearly identified.

Example:

NOTE: A fracture of any of the following site with fracture of other bones - see Fracture, multiple.

"Closed" includes the following descriptions, with or without delayed healing, unless they are specified as open or compounded:

comminuted greenstick
depressed impacted

Etiology and manifestation
--These codes are listed together in this volume. The etiology, or underlying cause of a disease, is listed first. The manifestation, or the signs or symptoms associated with the disease, is listed in brackets after the etiology code.

Example:

For a patient who is an alcoholic with complications from alcoholism the following would be true. Etiology = alcoholism Manifestation = seizures and ataxia

ICD-9-CM Coding Conventions

Match the ICD-9-CM convention with the description of why that convention is used.

see	This term follows a main term and is shown in parentheses. This convention does not affect the main term's code, but further describes the main term.
NEC	This convention should only be used when a coder lacks precise information necessary to code a term more specifically.
Nonessential Modifiers	Indicates the coder should look up the term specified to find the correct code.
Notes	Information that further declines or clarifies the main term. This information is typically boxed off on the pages of Volume 2.

<u>Volume 1</u> (the Alphabetic Index) includes the following conventions:

	Examples
: (Colon) --Used after an incomplete term which needs one or more modifying terms that follow to make it assignable to a given category	476.0 Chronic laryngitis Laryngitis: catarrhal hypertrophic sicca
[ ] (Brackets) -- Used to enclose synonyms, wording, or explanatory phrases	460 Acute nasopharyngitis [common cold]

[ ] (Slanted brackets)
--Used to enclose italicized codes which indicate the need to use more than one code to a diagnosis

Decubitus (ulcer) 707.0
With gangrene 707.0 *[*785.4*]*

} (Brace)
--Used to enclose a series of terms, each of which is modified by the statement appearing at the right of the brace.

Example:
098.2 Chronic, of lower genitourinary tract
Gonococcal:
Bartholinitis
Urethritis
Vulvovaginitis
Gonorrhea:
NOS
Genitourinary (track)

Any condition classifiable to 098.0

() (Parentheses)
--Used to enclose supplementary words which may be present or absent in the statement of a disease or procedure, without affecting the code to which it is assigned.

Example:
464.2 Acute laryngotracheitis
Laryngotracheitis [acute]
Tracheitis [acute] with laryngitis [acute]

"NOS" (Not otherwise specified)
-- This abbreviation is the equivalent of "unspecified." It is used to provide codes for nonspecific conditions and should only be used when the physician cannot provide a more specific diagnosis.

Example:

038.9 Unspecified septicemia
Septicemia NOS

Notes
--Volume 1 notes further define terms or clarify information, but are not boxed like Volume 2 notes.

Example:

Blindness and low vision
Note: Visual impairment refers to a functional limitation of the eye (e.g., limited visual acuity or visual field). It should be …

Includes
--Terms appearing directly below the three-digit category that further defines the contents of the category.

Example:

477 Allergic rhinitis
INCLUDES: allergic rhinitis
(nonseasonal)(seasonal)
hay fever
spasmodic rhinorrhea

Excludes
--Terms identifying conditions that are excluded from a category, and must be coded elsewhere.

Example:

207 Other specified leukemia

EXCLUDES: leukemia
reticuloendotheliosis (202.4)
Plastic cell leukemia (203.1)

"Use additional code…"
--This note appears in categories where the user must add further information (by using an additional code) to give a more complete picture of the diagnosis or procedure.

Examples
…Use additional code to identify infectious organism…

"Code first underlying disease…"
--This note is used in categories not intended to be the primary diagnosis. This instructs the coder that the underlying disease should be recorded first and the particular manifestation second.

…Code first underlying disease as: alcoholism…

"A:"
--This symbol references age indicators. Not all ICD-9-CM publications list age indicators.

Age indicator:
259.1 Precocious sexual development and puberty, not elsewhere classified A:0-17
V24.0 Immediately after delivery care and observation in uncomplicated cases A:12-55
414.0 Coronary atherosclerosis A:15-124

♀ (sex indicator)
--This symbol is used to indicate codes used for female patients.

Example:

Sex indicator:
219 - other benign neoplasm of uterus
219.0 Cervix uteri ♀

♂ (sex indicator)
--This symbol is used to indicate codes used for male patients.

Example:

Sex indicator:
222 - benign neoplasm for male genital organ

222.0 Testis ♂

(fifth digit indicator)
--This symbol indicates a fifth digit is necessary when coding. The symbol may be different for different publishers.

(Note: Not all publications have sex indicators.)

Identify what the underlined term or convention in each sample indicates to a coder by correctly matching each sample on the left with the correct description on the right.

Appendicitis: Chronic Recurrent	Further defines the main term and is used within the three-digit category
Inguinal hernia NOS	Indicates "unspecified" and is used to provide codes for nonspecific conditions (should only be used where specific information is truly not available)
INCLUDES bubonecele	Modifiers that follow the main term to make it assignable to a code

ICD-9-CM Coding Conventions Review

Volume 1 Coding Conventions:

> Punctuation - colons, brackets, braces, and parentheses
> Instructional Notes - "Use additional code...", "Code also…", and "Code first underlying disease…"
> Includes and Excludes
> NOS (Not otherwise specified)

Volume 2 Coding Conventions:

> Modifiers - Essential and Nonessential
> Cross-References - "See", "See also", and "See category"
> Eponyms (diseases/syndromes named for persons)
> Instructional Notes: used to: define terms, provide coding instructions, and provide fifth digit information
> NEC (Not elsewhere classified) Etiology and Manifestation

Select the following statements that are true about Volume 2, the Alphabetic Index.

- Contains alphabetic index of main terms
- Volume in which initial diagnosis search should begin
- Eponyms can be found in this volume by using only one method

A disease or syndrome named after a person that is listed in Volume 2, the Alphabetic Index, under the name of the disease, or under the main terms "Disease" or "Syndrome" is known as a(n) _____.

- Etiology
- Manifestation
- Eponym

Other ICD-9-CM Sections

After completing this lesson, you should be able to:

- Identify the concepts and terms that are true of the ICD-9-CM V and E codes as appropriate to accurate coding.
- Identify the tables in Volume 2 from which diagnosis codes can be selected.
- Match the six neoplasm classifications in the table with the correct explanation of their appropriate use.
- Identify the three main elements by which hypertension conditions are categorized according to the hypertension table.

- V Codes
- E Codes
- Tables
- Appendices

Match the three hypertension categories with the correct description for that category.

Malignant	Hypertension that is chronically high and is difficult to treat.
Unspecified	A mild chronic hypertension condition that can usually be controlled with medication and is the most common type.
Benign	Hypertension for which the details of the condition are not available or are unknown.

Select the Neoplasm Table column in which you would locate the diagnosis code for the narrative description shown below.

Narrative description:

A physician treated a patient for cancerous cells in the abdominal esophagus. The patient was treated previously for metastatic cancerous cells in the stomach.

- Malignant, Primary
- Malignant, Secondary
- Malignant, Ca in Situ
- Uncertain Behavior

Select the correct diagnosis code for the narrative description given below. (Use your ICD-9-CM volumes to find the answer.)

Narrative description:

The patient suffers from benign hypertension due to a renal embolism.

- 405.11
- 405.1
- 405
- 405.01

Completing the Forms

After completing this lesson, you should be able to:

- Identify reasons why claims might be denied.
- Match the claim form or format with its correct description.
- Identify the appropriate contents for diagnosis coding fields on claim forms
- Identify the necessary contents of a Waiver or Advanced Beneficiary Notice.

The Medicare Catastrophic Coverage Act of 1988 requires physicians to include a diagnosis code (or codes) on each request for Medicare Part B (physicians' offices) payment.

Medicare Part A providers (hospital and skilled nursing facilities) have had to submit diagnosis codes for many years in order to get reimbursed.

Penalties for non-compliance can include claim denials, and/or fines or sanctions.

If a Medicare Part B claim is submitted without an ICD-9-CM code, it will be denied or returned as unprocessable. Claims will also be denied if the diagnosis codes are not coded to the highest level of specificity.

The main forms used to submit claims to Medicare for reimbursement are:

- HCFA-1450 UB-92 (commonly referred to as UB-92)
- HCFA-1500 (US) (12-90)

The HCFA-1450 UB-92 form used by Medicare Part A providers is used for claim filing.

The most significant fields on this form related to diagnosis coding are:

- Field 67: Principal Diagnosis Code
- Fields 68-75: Other Diagnosis Codes
- Fields 76: Admitting Diagnosis
- Field 77: External Cause of Injury

The Principal Diagnosis Code on the UB-92 is an extremely important field and is required for all inpatient bills and all outpatient registration claims.

At least one code is required on all UB-92 claims, with the exception of "non-patient" claims. This is the primary field that Medicare uses to determine the reimbursement level at which your organization will receive payment for inpatient services.

This should contain the code for the problem or procedure believed to be chiefly responsible for the services performed.

- For inpatient services--even if other diagnoses may be more severe, enter the code for the "principal" reason for admission

- For outpatient services--if during evaluation and treatment a definitive diagnosis is made, use the code for the determined diagnosis.

The Other Diagnosis Codes fields (68-75) are used for entering codes for diagnoses that co-exist at the time of admission, or develop after admission for in-patient services; and at the time of encounter or visit for out-patient services.

The Admitting Diagnosis field (76) is only required for in-patient hospital or SNF bills. Only one admitting code should be reported. The admitting diagnosis may be a repeat of the "principal diagnosis."

The External Cause of Injury field (77) is not required, but is encouraged. This is very useful information for reporting or statistical purposes and should be coded whenever there is a diagnosis of an injury, poisoning, or adverse effect.

What field or fields on this sample form have incorrect information?

- Field 67: Principal Diagnosis Code
- Field 68-75: Other Diagnosis Codes
- Field 76: Admitting Diagnosis
- Field 77: External Cause of Injury

The HCFA-1500 form is used by Medicare Part B providers (physicians' offices) to file Medicare claims.

The only fields related to diagnosis coding on the HCFA-1500 form are:

- Field 21: Diagnosis or Nature of Illness or Injury
- Field 24e: Diagnosis Code

The Diagnosis or Nature of Illness or Injury field (21) is used to enter up to four ICD-9-CD diagnosis codes for a patient. The codes should be entered in priority order (primary, secondary, etc.).

Field 24e (diagnosis code field) may be used to report only one diagnosis reference code number from field 21. The reference number selected for entry into field 24e should be the one that represents the most significant reason for the visit or encounter.

What information belongs in field 24e on the HCFA 1500 form?

- A description of the condition being treated.

- All diagnosis codes listed in field 21 that describe all conditions.

- The diagnosis code reference number from block 21 for the diagnosis code chiefly responsible for the visit.

There are also two electronic formats used to submit the Medicare claim forms. Many providers prefer filing electronically because processing and reimbursement is quicker than filing paper claims.

Providers must adhere to all the ICD-9-CM coding standards when filing any type of claim. The formats currently in use are:

- ANSI - American National Standard Institute
- NSF - National Standard Format

The American National Standard Institute (ANSI) format allows Medicare claims to be processed electronically, and allows providers the flexibility of attaching certain reports (such as operational reports, office records, etc.).

The National Standard Format (NSF) form is also used to file electronic Medicare claims.

For more information on filing claims electronically, contact your local contractor's provider information or provider education department.

There is one other form that should be used on a regular basis by offices and medical facilities when there is a chance that services rendered may not be covered by Medicare: the Written Advanced Notice form.

This Waiver, or Advance Notice form, is proof that your office has given patients notice that the services about to be provided may not be covered under Medicare, and that they are responsible for the charges that are not covered.

The provider must make note on paper or electronic forms when advance notice is given to a patient. This is noted by using the procedure code modifier "GA" with the service or item code. If a provider fails to use the Written Advanced Notice form and the "GA" modifier on the claim form, that provider may be responsible for charges if the claim is denied.

Medicare Part B only allows coverage for services and items which are "medically reasonable and necessary" for treatment/diagnosis of a patient.

Medical necessity may be determined according to several factors. A few of these factors include general rules such as:

- Items or services provided to the patient must be appropriate for that patient's treatment/diagnosis.
- Documentation (when identified as required, or when requested) supports the medical need.
- The frequency of service or dispensing of an item is within the accepted standards of medical practice.

There are some guidelines as to what constitutes an acceptable Written Advanced Notice. These guidelines are:

- Notice must be given in writing, prior to providing the patient with an item or service.

- Notice must include:

  - The patient's name
  - Date(s)
  - Description of item or service
  - Reason(s) why the item or service may not be considered medically necessary

- The notice must be signed and dated by the patient each time an item is given or service is rendered that may not be deemed "medically necessary."

When must a Written Advanced Notice form be signed and dated by a patient?

- Prior to providing an item or service that is considered a program exclusion, and subsequently denied

- Prior to providing an item or service that may not be deemed "medically necessary"

- For all items or services provided to a patient whether you believe it may be denied or not

Difficult Diagnosis Coding Situations

After completing this lesson, you should be able to:

- Identify the reason(s) certain conditions are more difficult to code.

- Identify the information necessary to code correctly for given sample coding situations.

- Select the statements from a list that are true in relation to coding for burns, diabetes, injuries, complications, or accidents.

There are some specific coding issues that can be difficult for many coders to understand and apply. You should be especially careful when coding for these situations.

- Burns
- Diabetes
- Injuries, Complications, and Accidents

Hypertension, neoplasms, poisonings, and adverse effects can be difficult to code as well, but these situations are discussed in the Tables section of this course.

Difficult Diagnosis Coding Situations

- Burns
- Diabetes
- Injuries, Complications and Accidents

Burns

Coding burns is unique because it is based on four basic elements:

1. Location of the burn
2. Degree of severity of the burn
3. Percentage of the total body burned
4. Percentage of the total body with 3rd degree burns

The factors listed above are used to determine the correct codes to use, but coding burns accurately always require at least two codes.

- One code is used to describe the location and degree of severity of the burn.
- The second code is used to describe the percent of total body burned, and percent of the body with third degree burns.

Example: A patient comes into a physician's office with first-degree burns on her anterior trunk and second-degree burns on the face and neck. Coding would be

as follows:

Burn of trunk	942.10	Burn of trunk (942) Erythema (first degree) (.1) Trunk, unspecified (0)
Burn of face, head, and neck	941.29	Burn of face, head and neck (941) Blisters, epidermal loss (second degree) (.2)
% of Body	948.20	Burns classified according to extent of body (948) 20-29% of body surface (.2) Less than 10% third degree burns (0)

Note: The "Rule of Nines" is used to determine the percentage of body burned. Press Print for the "Rules of Nines" breakdown.

Additional Burn Coding Information

According to the "Rules of Nines," the body is basically divided into eight areas:

Head and Neck	9%
Posterior Trunk	18%
Anterior Trunk	18%
Left Arm	9%
Right Arm	9%
Posterior Leg	18%
Anterior Leg	18%
Genitalia	1%
	100%

Example:

A patient comes to the physician's office with first-degree burns on their anterior trunk and second-degree burns of the face and neck. Coding would be as follows:

Burn of the trunk	942.10 Burn of the trunk (942) Erythema [first degree] (0.1) Trunk, unspecified (0)

Third degree burns present a challenge to the coder.

- Category 948 is to be used when the site of the burn is unspecified, or when you use categories 940 through 947 when the site is specified.

- Category 948 is used to report the extent of the total body surface burned. When using category 948, the fifth digit is used to indicate the percentage of the body surface with third degree burns.

Select the item from the list that is used to determine an accurate burn code.

- Circumstances of the burn (e.g., house fire, chemical substance, etc.)

- Degree of severity of the burn

- Location on the body of the burn(s)

- Percent of body with 2nd degree burns

- Percent of total body with burns

- Percent of body with 3rd degree burns

Select the correct diagnosis codes for the sample narrative description given below. (Use your ICD-9-CM to find the correct codes.)

Narrative description:

A patient is treated for 2nd degree burns on both forearms (9% of the body for each arm). The hands and wrists are not burned.

- 943.30, 948.10

- 943.21, 948.11

- 943.21, 948.10

Diabetes

Diabetes presents a unique coding situation because the coding is based on the patient's diabetes type classification.

This classification is based on the patient's insulin dependence rather than a medical condition.

There are two main types of diabetes: Type I and Type II.

Determination of diabetes type and insulin dependence is key to coding diabetes treating accurately.

There are other complex coding situations that are related to the complications that patients suffer as a result of their diabetes. A list of some of those coding situations can be printed from the next screen.

Diabetes

A fifth digit is required for coding diabetes. The fifth digit assignment is based on the type classification and nature of the patient's diabetes management.

Fifth digit:	Classification:
0	**Type II -** **[non-insulin dependent type] [NIDDM type]** **[adult-onset type] or unspecified type, not stated as uncontrolled** Fifth-digit 0 is for use for type II, adult-onset diabetic patients, even if the patient requires insulin
1	**Type I - [insulin dependent type] [IDDM] [juvenile type],** **Not stated as uncontrolled**
2	**Type II -** **[non-insulin dependent type] [NIDDM type]** **[adult-onset type] or unspecified type, uncontrolled** Fifth-digit 2 is for use for type II, adult-onset Diabetic patients, even if the patient requires insulin
3	**Type I -** **[insulin dependent type] [IDDM] [juvenile type], uncontrolled**

Select the necessary fifth digit based on the narrative description given below.

Narrative description:
The patient has adult-onset diabetes being controlled by regular insulin shots.

- 0
- 1
- 2
- 3

Injuries, Complications, and Accidents

Situations involving injuries, complications, and accidents can be difficult because you must ask yourself a series of questions before you can determine how the problem or condition can be coded.

Many details are needed about the circumstances of the condition or problem caused by an injury, complication, or accident in order to code accurately.

Injuries are coded differently for:

- Internal versus external
- Injuries to blood vessels
- Fractures (coded according to exact bone and whether the fracture is open or closed)

Scenario:

A patient suffers a fracture to the skull bone covering his frontal lobe. The injury was caused by a car accident on the highway in which he was driving. The wound is open, but there is no evidence of intracranial injury.

800.51 - Fracture of Vault of Skull [800], open without mention of intracranial injury [800.5], with no loss of consciousness

*E815.0 - Other motor vehicle traffic accident involving collision on the highway, driver of vehicle other than motorcycle
(*For use by Part A providers only; Part B providers are not required to use E codes.)

In many cases, complications are coded according to a specific body system.

On the claim form, the diagnostic code should relate to the surgical procedure, and the complication code should relate to the medical care.

The complication code is usually the secondary code on the claim form since it was not the primary reason for the visit/encounter.

Scenario:

During a routine tonsillectomy, the patient begins hemorrhaging.

474.00 - chronic tonsillitis
998.11 - hemorrhage complicating a procedure

Accidents are more complex to code because you must use several codes to identify the injury and the circumstances of the injury.

E codes are used to describe the circumstances, such as the location where the injury took place and any object(s) involved in the injury.

Example:

It usually takes more than one E code to code the situation accurately, but the place of occurrence is usually the most important and should be listed before the other E codes.

Medicare Part B providers do not normally need to use E codes, but Medicare Part A providers are encouraged to use E codes.

Match the difficult coding situation with the statement that appropriately describes the key item to remember when coding for each situation.

Accident	These are coded differently for internal versus external, if blood vessels are involved, or if there is a fracture.
Injury	There are two codes necessary here. One is needed for the surgical procedure and one for the difficulty encountered during the procedure.
Complication	Usually several codes are needed in order to determine the circumstances of the event accurately.

There are many other situations for which coding can be difficult. Many times it is because the nature of the illness or injury itself can be complex.

Some other difficult coding situations include:

Cardiac/Circulatory System -- these problems can occur over a long period of time and are coded based on the current state of the heart condition in many cases.

Late Effects - this is a long-term effect from a previous illness or injury for which you must code what caused the late effect after the primary code

Anomalies - unique conditions in a patient for which you need to determine if the condition is congenital (present since birth), or acquired

Click the Medicare Expert for more important information:

Make sure to check with your local Medicare contractor if you are unsure how to code for difficult diagnoses or treatments. Your ICD-9-CM volumes may also provide information that helps guide you through difficult coding situations.

Often times, the problem is not that coders cannot find the appropriate code in the manual, but that they have not been provided with enough information.

When a treatment or diagnosis statement from a physician is too general or does not match the descriptions in the ICD-9-CM manual, you need to investigate and get the information necessary to code correctly.

Use the medical record to get clarification, or go to the physician and ask questions.

Be sure to only code those diagnoses, symptoms, conditions, or problems documented in the medical record. Do not read more into a diagnostic or procedural description than was intended by a physician.

Click the Medicare Expert and Example button for more information:

An example of a coding situation where the doctor's notes may not match the terms in the ICD-9-CM is "strep throat."

The Alphabetic Index (Volume 2) list "Streptococcus" and "Throat," but no codes are provided for either.

Instead of giving up, you should ask more about the condition.

Strep throat is an infection. By looking under "infection" in the Volume 2 Index, you will see subterms "throat" and "streptococcal," and be able to locate the proper code.

There are some important tips to keep in mind about your ICD-9-CM manual. They are:

- Make sure you are very familiar with the conventions of your ICD-9-CM publication.
- Use only the most current ICD-9-CM version available.
- Read all the information available in your ICD-9-CM for the headings, categories, and additional digits.

Typically, the ICD-9-CM volumes guide you to the correct codes, but you need to take the time to read through information thoroughly once you have all the facts about the patient.

In addition to difficult coding situations, there are also cases where you will need to recognize the need for "multiple" or "combination" codes.

Multiple coding means that two or more codes are used together to accurately identify a diagnosis. Multiple codes are necessary whenever you see that the ICD-9-CM notes "Use additional code" or "Code also underlying disease."

A combination code is one code that describes conditions that frequently occur together. Combination terms are often listed as subterms in the Alphabetic Index. Some key words that indicate a combination term are:

- "associated with"
- "complicated by"
- "due to"
- "following"
- "secondary to"
- "with" or "without"

Post-Course Knowledge Assessment

Now it is time to take the Post-Course Knowledge Assessment to determine how much you have learned from this course about diagnosis coding and the ICD-9-CM.

This Assessment will ask you to answer questions related to the content of this course. Please note that you will not be able to exit the Assessment once you enter it.

Assessment feedback is given after you have answered all questions, and indicates which questions you answered incorrectly. Correct answers to the questions will also be provided in the Assessment feedback.

Finally, you will have the option to print your "Score Report" which contains your Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores. You may re-take the Post-Course Knowledge Assessment as often as you like.

What is the correct definition of a diagnosis code?

- A code used to determine how much money a provider will get for procedures performed at a healthcare facility.
- A numeric or alphanumeric code translated from medical terminology that is used to describe each service and/or item provided to a patient by a physician's office or other healthcare facility.
- Five digit codes used to represent surgical procedures performed by hospitals or skilled nursing facilities.

Match each ICD-9-CM component with the volume in which you would find that component.

Coding reference for hospitals	
Chapter headings	Volume 1: Tabular/Numeric List of Diseases
Disorders grouped by body system or condition	Volume 2: Alphabetic Index of Diseases
Diagnosis, symptom, or condition description	Volume 3: Alphabetic Index and Tabular List of Procedures
Neoplasm Table	

Match each ICD-9-CM convention with the description of its use.

Includes	Indicates a need to use more than one code to a diagnosis; this is not the primary code
// slantedbrackets	Enclosed supplementary words
() parentheses	Terms following this indicator further define the diagnosis

Translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Multiple corns and callosities on both feet

Translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Malignant carcinoma of the large intestine, first occurrence of a malignant tumor in this patient

Select the accurate diagnosis code(s) from the list based on the narrative description given below.

Narrative description: Adult-onset diabetes controlled with insulin; bone changes in hands as a manifestation

- 250.8
- 250.80, 731.8
- 731.8
- 250.8.731.8

Translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Fracture (open) of the ileum (hip area of the pelvis)

Translate the narrative description given below into an accurate diagnosis code.

(Type the exact code in the blank as you would enter it on a paper or electronic claim form. Be careful not to type any extra spaces or characters.)

Narrative description: Viral pneumonia due to adenovirus

What is the first step of translating a narrative description into an accurate diagnosis code?

- Locate the code from the Alphabetic Index in the Tabular Index (Volume 1).
- Ensure you have considered all color coding marks that exist (e.g., age and sex) before selecting the final code.
- Look up the main term in the Alphabetic Index (Vol. 2) and scan through the subterms if necessary. Follow any references.
- Observe the punctuations, footnotes, cross-references, color-code prompts, or other conventions present in Vol. 1 for your code. Also determine the appropriateness of the code selection by checking the Includes, Excludes, additional digit requirements, or other instructional notes.

What codes are used when treatment or diagnosis is necessary for a condition or problem that is not caused by a disease or injury, but due to certain circumstances?

These circumstances often involve contact with healthcare facilities or personnel and usually affect a person's health status.

- H codes
- C codes
- E codes
- V codes

_____ are used to describe additional details of an accident or event. They are located in the Table of Drugs and Chemicals and at the end of Volume 2.

- H codes
- C codes
- E codes
- V codes

Select each statement below that is true regarding diagnosis codes and Medicare claim forms.

- Paper and electronic claims are accepted by Medicare contractors. Providers filing accurate electronic claims usually receive reimbursements quicker than do providers filing paper claims.

- The HCFA-1500 is the primary paper claim form used by hospitals and skilled nursing facilities.

- The HCFA-1500 is the primary paper claim form used by physicians' offices.

- The Diagnosis Code field (block 24E) on the HCFA-1500 claim form can contain only one reference code per line.

Is the form below filled out correctly?

- Yes
- No

What form is necessary whenever an item or service is rendered that may not be considered "medically necessary," and possibly denied?

- HCFA-1500
- Waiver of Claim Submittal
- Written Advanced Notice
- Warning to Deny Services

Select all the items that are important to efficient and accurate coding.

- Code for all notes recorded in the medical record, even "rule out" or suspected conditions.
- Code to the highest level of specificity.
- Use any ICD-9-CM version; it has not been updated since 1977
- Code to the lowest level of specificity

You scored ____ correct on the Post-Course Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

1	2	3	4	5	6	7	8	9	10

Your course "Score Report" containing both the Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores can be obtained by clicking the Print Button below. Diagnosis Coding: Using the ICD-9-CM course certification is given to individuals scoring 90% or better on the Post-Course Knowledge Assessment.

Note: You may increase your final score by retaking the Post-Course Knowledge Assessment at any time. Click the Menu button to do this now.

(End of Diagnosis Coding: Using the ICD-9-CM Section)

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